

# Whitney High School

Physical Evaluation – Page 1 (to be completed by parent/guardian)

Student Name: \_\_\_\_\_  
ID # (9 digit): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Gender: Male \_\_\_\_ Female \_\_\_\_ (Check one)  
Sport(s): \_\_\_\_\_  
Grade Level: 9      10      11      12 (Circle one)  
Physician Name: \_\_\_\_\_  
Physician phone: \_\_\_\_\_  
Medical Ins. \_\_\_\_\_  
Policy Number: \_\_\_\_\_

### Complete the information below.

- Yes \_\_\_\_ No \_\_\_\_      Have you ever been hospitalized?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever had surgery?  
Yes \_\_\_\_ No \_\_\_\_      Are you presently taking any medication?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever passed out during or after exercise?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever been dizzy during or after exercise?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever had chest pain during or after exercise?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever had high blood pressure?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever had racing of your heart or skipped heartbeats?  
Yes \_\_\_\_ No \_\_\_\_      Has anyone in your family died of heart problems or a sudden death before age 50?  
Yes \_\_\_\_ No \_\_\_\_      Do you have any skin problems (itching, rashes, etc.)?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever had a head injury?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever been knocked out of unconscious?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever had a seizure?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever had a stinger, burner, or pinched nerve?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever had heat or muscle cramps?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever been dizzy or passed out in the heat?  
Yes \_\_\_\_ No \_\_\_\_      Do you have trouble breathing or do you cough during or after activity?  
Yes \_\_\_\_ No \_\_\_\_      Do you use any special equipment (pads, braces, mouth guard, eye guard, etc.)?  
Yes \_\_\_\_ No \_\_\_\_      Have you had any problems with your eyes or vision?  
Yes \_\_\_\_ No \_\_\_\_      Do you wear glasses, contacts, or protective eyewear?  
Yes \_\_\_\_ No \_\_\_\_      Have you ever sprained, strained, dislocated, fractured, or had repeated swelling of any bones/joints?  
Yes \_\_\_\_ No \_\_\_\_      Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?  
Yes \_\_\_\_ No \_\_\_\_      Have you had a medical problem or injury since your last evaluation?  
Yes \_\_\_\_ No \_\_\_\_      Are you missing any paired organs?

1. Explain any "yes" answers from above. \_\_\_\_\_  
\_\_\_\_\_
2. When was your last tetanus shot? \_\_\_\_\_
3. When was your last measles immunization? \_\_\_\_\_
4. Are there other medical concerns the athletic department needs to be aware of? \_\_\_\_\_  
\_\_\_\_\_

**By signing below I hereby state that to the best of my knowledge, the answers above are correct.**

Signature of athlete: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# Whitney High School

Physical Evaluation – Page 2 (to be completed by physician)

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Pulse: \_\_\_\_\_

Vision: Right 20/\_\_\_\_ Left 20/\_\_\_\_

Corrected: \_\_\_\_\_

Pupils: \_\_\_\_\_

Allergies: \_\_\_\_\_

Category	Normal	Abnormal	Initials
Cardiopulmonary			
Pulses			
Heart			
Lungs			
Tanner Stage (1-5)			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance (check the appropriate box below):

- Cleared
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- Not cleared for (please circle appropriate box)
  - Collision
  - Contact
  - Non-contact

Recommendation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_